

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3958

CERTIFICATE OF DEATH

03948

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE New York		b. COUNTY Suffolk		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville, Rural		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patchogue, Long Island, N.Y.		d. STREET ADDRESS 287 South Ocean Ave. 69X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Canvas Back Inn				d. STREET ADDRESS 287 South Ocean Ave. 69X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First John	Middle Cooper	Last Barrie	4. DATE OF DEATH April	Month Month	Day 26	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 18, 1878	9. AGE (in years last birthday) 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Dealer	10b. KIND OF BUSINESS OR INDUSTRY Owner	11. BIRTHPLACE (State or foreign country) Scotland	12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John	Barrie	14. MOTHER'S MAIDEN NAME Annie M. Cooper						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT Anna H. Barrie, Patchogue, L.I., N.Y.	287 South Ocean Ave., Patchogue, L.I., N.Y.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Arterio Thrombosis Hypertension Disease Coronary Thrombosis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Patchogue	(County)	(State)	
21. I certify that I attended the deceased from April 27, 1957, to April 26, 1957, that I last saw the deceased alive on April 26, 1957, and that death occurred at 3:30 AM, from the causes and on the date stated above. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Charles J. Foley, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-29-1957	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Grove	22d. LOCATION (City, town, or county) Patchogue,	(State) N.Y.				
23. FUNERAL DIRECTOR'S SIGNATURE Vera Patterson, Jr.	ADDRESS Perryville, Md.	24a. REC'D BY REGISTRAR DATE 4-26-57	24b. REGISTRAR'S SIGNATURE Gene E. Daugherty					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03949
96

CERTIFICATE OF DEATH

Reg. Dist. No.

3950

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 8mo. 21 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen 12X72	
3. NAME OF DECEASED (Type or print) WILLIAM		First (W)	Middle BOYD
4. DATE OF DEATH April		Month 18	Day 19 57
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2-26-19
9. AGE (In years lost/birthday) 38	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Boyd - Deceased		14. MOTHER'S MAIDEN NAME Elizabeth (?) - Deceased	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the urinary bladder Grade IV with INTERVAL BETWEEN 181X widespread abdominal metastases to the bones & lungs ONSET AND DEATH DUE TO Pyelonephritis, left, severe Unknown			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Pyelonephritis, left, severe Unknown			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 28 , 1956, to April 18 , 1957, and that death occurred at 9:40 AM and that death occurred at 9:40 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) N.D. V.A. Hospital, Perry Point, Md. DATE SIGNED 4-18-57			
ACTUAL SIGNATURE <i>W. Oppler</i>			
PHYSICIAN'S NAME (Type) W. OPPLER Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremated		22b. DATE THEREOF 4-28-57	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary		22d. LOCATION (City, town, or county) Aberdeen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington & Son</i>		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DATE 4-20-57		24b. REGISTRAR'S SIGNATURE <i>Irene E. Daugherty</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
APR 23 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3960

CERTIFICATE OF DEATH

Reg. Dist. No.

03950
96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural		c. LENGTH OF STAY IN 1b 42 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harmony Chapel Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x/ Port Deposit, Rural	
3. NAME OF DECEASED (Type or print) First Eva		d. STREET ADDRESS / Harmony Chapel Rd.	
4. DATE OF DEATH April 23 1957		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 2, 1883	
9. AGE (In years last birthday) 73		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David		14. MOTHER'S MAIDEN NAME Mary R. Gray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 17. INFORMANT W. James Purlin, Perryville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		INTERVAL BETWEEN ONSET AND DEATH 1 hour.	
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		8 yrs -	
DUE TO (c) Hypertension		8 yrs -	
Arterio-Sclerosis -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocarditis -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 1954 to April 2, 1957</u> , that I last saw the deceased alive on <u>April 22, 1957</u> , and that death occurred at <u>4:55</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Clarence Johnson, M.D., Port Deposit, Md.	
ACTUAL SIGNATURE Clarence Johnson, M.D.		DATE SIGNED April 24, 1957	
PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-26-1957	
22c. NAME OF CEMETERY OR CREMATORIAL Hopewell		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Ella Patterson & Son, Perryville, Md.		24a. RECD BY REGISTRAR DATE 4-25-57	
		24b. REGISTRAR'S SIGNATURE Diane E. Daugherty	

DEPARTMENT OF DEFENSE - STATE QUARTERS

STATE OF DELAWARE

RECEIVED

APR 29 1957

BUREAU Y. S.

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3946

CERTIFICATE OF DEATH

03951

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Port Deposit	
3. NAME OF DECEASED (Type or print) Isaac		d. STREET ADDRESS 1 Race St	
4. DATE OF DEATH 4 Month 15 Day Year 19 57		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1- 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Day	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Richard		14. MOTHER'S MAIDEN NAME Campbell Sallie Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT 218-06-6810 Nellie Griffin, Race St., Port Deposit, Md.	
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia, right lower lobe, cause undetermined			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 4, 1957, to April 14, 1957, that I last saw the deceased alive on April 14, 1957, and that death occurred at 2:50 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE S. Ralph Andrews, Jr., M.D. 233 E. Main St., Elkton, Md. 4/15/57 DATE SIGNED			
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.			
22a. BURIAL, CREMATION, REMAINS? (Specify) Burial		22b. DATE THEREOF 4-17-1957	
22c. NAME OF CEMETERY OR CREMATORIUM Jones Memorial		22d. LOCATION (City, town, or county) Port Deposit, Md. Rural (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Leva Patterson & Son		24a. REC'D BY REGISTRAR ADDRESS Perryville, Md. DATE 4/17/57	
24b. REGISTRAR'S SIGNATURE J. R. Brauer			

DEPARTMENT OF STATE BUREAU OF INTELLIGENCE
CERTIFICATE OF DEATH

BUREAU V. S

APR 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3961

CERTIFICATE OF DEATH

03952

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenburnie 02X22	
3. NAME OF DECEASED (Type or print) ALBERT		First Middle 0.	Last 4. DATE OF DEATH April 2 Month Day Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-31-86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchmaker		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas J. Casserly		14. MOTHER'S MAIDEN NAME Elizabeth Winebasner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I	
17. INFORMANT Address		Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 12-14 days Pneumonia lobar, left lower lobe	
(b) DUE TO Abscess left lower lobe, staphylococcus aureus		Approx. 1 week	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 002X Tuberculosis pulmonary, far advanced, inactive - unknown		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 23, 1957, to April 2, 1957, and that death occurred at 12:30 p.m. from the causes and on the date stated above. ACTUAL SIGNATURE W. Oppier M.D. V.A. Hospital, Perry Point, Md. 4-3-57			
Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-3-57	
22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Rennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 4-5-57	
ADDRESS		24b. REGISTRAR'S SIGNATURE Irene E. Daugherty	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CEMETERY OF DEATH

1951

BUREAU U. S.

APR 8 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03953

3947

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
CECIL MARYLAND		a. STATE Md b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
ELKTON		5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
Union Hospital		1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
REBECCA		J.	CHURCH
4. DATE OF DEATH		Month	Day
2-14-1887		4	14
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
FEMALE		WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR Months Days Hours Min
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Housework		—	DEEP GAP N.C
12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MOTHER'S MAIDEN NAME	
ALEXANDER CHURCH		LIDD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT	
—		Name John C Church North East Md	
Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Hyper Tensive Cardiovascular Renal Disease	
442 X DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
Conditions, If any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b)	
DUE TO		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 April 1952 to 14 April 1952, that I last saw the deceased alive on 14 April 1952, and that death occurred at 2 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Klaus H. Huebner M.D. No. 16 East, 13d 14 April 1952	
ACTUAL SIGNATURE		22. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	
22b. DATE THEREOF 4-15-1957		22c. NAME OF CEMETERY OR CREMATORIAL Patton's Ridge	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		24. LOCATION (City, town, or county) C. Elgin N. C.	
ADDRESS North East Md		24a. REC'D BY REGISTRAR DATE 4/15/57	
24b. REGISTRAR'S SIGNATURE J. P. Fraser			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3962

CERTIFICATE OF DEATH

03954

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b 41 yrs		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md b. COUNTY Cecil	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Aikin Ave		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		d. STREET ADDRESS Aikin Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Morris	Middle Cole	4. DATE OF DEATH April	Month 7	Day 19	Year 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 31, 1895	9. AGE (In years [last] birthday yrs.) 61	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor		10b. KIND OF BUSINESS OR INDUSTRY Pa. R.R.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anthony		14. MOTHER'S MAIDEN NAME Cole		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 17. INFORMANT 717-07-5940. Virgie Cole, Perryville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 18IX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO (b) DUE TO (c)		genital Circumcisio Carcinoma of bladder		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. [City or town] Port Deposit	(County) Md.	(State) Rural
21. I certify that I attended the deceased from January 1957 to April 7, 1957, that I last saw the deceased alive on April 7, 1957, and that death occurred at 11:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. <i>Edward Simon</i> <i>House 108 Grace</i> DATE SIGNED ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) Edward Simon, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-10-1957		22c. NAME OF CEMETERY OR CREMATORIAL Asbury		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leeda Patterson & Son</i>				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE 4-8-57	
						24b. REGISTRAR'S SIGNATURE Dame E. Daugherty	

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APR 11 1957

REGELIVEL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3948

CERTIFICATE OF DEATH

Reg. Dist. No.

03955

1. PLACE OF DEATH a. COUNTY ANNAPOLIS MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE ... MD ... b. COUNTY ... BOSTON ...		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN MD 1 week		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO North East		
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First William	Middle E.	Last Smith	
4. DATE OF DEATH 1957	Month July	Day 10	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-1881	
9. AGE (in years last birthday) 71 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Firebrick Co.		
10c. BIRTHPLACE (State or foreign country) Maryland		10d. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Washington Smith		14. MOTHER'S MAIDEN NAME Elizabeth Johnson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tex. no. or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-03-6576		
17. INFORMANT Dr. William H. Huchner		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. INTERVAL BETWEEN ONSET AND DEATH 3 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) —		(County) —		(State) —
21. I certify that I attended the deceased from <u>6 July</u> , 1956, to <u>26 April</u> , 1957, that I last saw the deceased alive on <u>26 April</u> , 1957, and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) Klaus H. Huchner M.D. North East, Md. DATE SIGNED 26 April 1957				
ACTUAL SIGNATURE Klaus H. Huchner PHYSICIAN'S NAME (Type) Klaus H. Huchner M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-4-1957	22c. NAME OF CEMETERY OR CREMATORIAL Morton	22d. LOCATION (City, town, or county) Baltimore	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Grane	ADDRESS North E. St., Baltimore	24a. REC'D BY REGISTRAR 4/29/57	24b. REGISTRAR'S SIGNATURE J. Grane	

BUREAU V. S

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BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3963

03956

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colora R.D.		b. COUNTY Cecil	
c. LENGTH OF STAY IN 1b All life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colora	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Annie	First E	Middle Creswell	Last 14
4. DATE OF DEATH 11-8-1872	Month 11	Day 14	Year 57
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-8-1872
9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months 84	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY House work	11. BIRTHPLACE (State or foreign country) Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edward Pierce	14. MOTHER'S MAIDEN NAME Jennie Shank	Address Mrs. Arthur Dinsmore, Rising Sun, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Arthur Dinsmore, Rising Sun, Md.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>R. C. Dodson</i>	DATE SIGNED 4-15-57		
EXAMINER'S NAME (Type) R. C. Dodson	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/17/57	22c. NAME OF CEMETERY OR CREMATORIAL Brookview Cem.	22d. LOCATION (City, town, or county) (State) Rising Sun, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph M. Reed</i>	ADDRESS Rising Sun, Md.	24a. REC'D BY REGISTRAR DATE Apr 16-56	24b. REGISTRAR'S SIGNATURE <i>John W. Thompson</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

REAU V. S.

APR 17 1967

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03957
092

Reg. Dist. No.

3949

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		b. COUNTY Cecil	
c. LENGTH OF STAY IN lb 5 ¹ hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East X	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First J. M.	Middle William	Last DeLancey
4. DATE OF DEATH	Month 4	Day 1	Year 1957
5. SEX	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 1920-10-13	9. AGE (In years to today) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Surveyor		10b. KIND OF BUSINESS OR INDUSTRY same	
11. BIRTHPLACE (State or foreign country) Perry Co., La		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Power DeLancey		14. MOTHER'S MAIDEN NAME Wolf	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 260-54-1533	
17. INFORMANT John DeLancey		Address Perry Beach Inc., Perry St. 1.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Surfing and this is the cause of death</u>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Surfing</u> .			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH X			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Using flame thrower and cloth to burn life			
20c. TIME OF INJURY Hour 5:15	Month, Day, Year a. m. 4-1	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) North East
20f. (City or town) Cecil		(County) Cecil	
(State) Md.		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. C. DeLancey	DATE SIGNED 1-1-57		
EXAMINER'S NAME (Type) R. C. DeLancey	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, Cremation, Removal (Specify) Burial	22b. DATE THEREOF 3-3-1957	22c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery	22d. LOCATION (City, town, or county) North East, Cecil Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph DeLancey		ADDRESS North East, Cecil Co., Md.	24a. REC'D. BY REGISTRAR DATE 4/3/57
			24b. REGISTRAR'S SIGNATURE F. J. Frazer

REAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3961 CERTIFICATE OF DEATH

03958
96

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 2741 Dunglen Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Alvin	Middle D. Feick	Last	4. DATE OF DEATH April 18, 1957	Month April	Day 18	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 16, 1923	9. AGE (In years at time of death) 33 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Keeper		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Feich				14. MOTHER'S MAIDEN NAME Kathaleen Laird			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 45 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 9, 1957, to April 18, 1957, and first saw the deceased at approximately and that death occurred at 5:50 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. V.A. Hospital, Perry Point, Md. DATE SIGNED 4-19-57							
ACTUAL SIGNATURE <i>W. Oppler</i>							
PHYSICIAN'S NAME (Type) W. OPPLER							
Director, Professional Services							
22a. BURIAL, CREMATION, REMAINS (Specify) Burial		22b. DATE THEREOF 4-22-57		22c. NAME OF CEMETERY OR CREMATORIAL BALT. VETERAN		22d. LOCATION (City, town or county) BALT. MD	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Pearson & Son. Perryville, Md. ADDRESS <i>Arthaudley</i> 24a. REC'D BY REGISTRAR VS A15 (4) 15M 9/55 DATE <i>APR 22 1957</i> 24b. REGISTRAR'S SIGNATURE <i>Jane Daugherty</i>							

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3965

CERTIFICATE OF DEATH

Reg. Dist. No. 03959

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE D. C.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 16 yrs. 7 mo. 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47 X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 103 - 3rd Street, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First LEONARD	Middle J.	Last FREEMAN	4. DATE OF DEATH April	Month April	Day 27	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5-6-98	9. AGE (In years lost birthday) 58 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Unknown		Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral, unresolved</u> INTERVAL BETWEEN 47 X ONSET AND DEATH DUE TO <u>(following operation)</u> 5-7 days Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Cyst post traumatic of occipital area right,</u> DUE TO <u>due to gun shot wound</u> unknown (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Arteriosclerosis general, moderate - unknown</u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) VA		(County)	(State)
21. I certify that I attended the deceased from <u>September 23, 19 40</u> , to <u>April 27, 19 57</u> , and that death occurred at <u>11:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. <u>V.A. Hospital, Perry Point, Md.</u> DATE SIGNED <u>Wiley Miller</u> 4-29-57							
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>W. OPPLER</u> Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 4-29-57		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Takoma Funeral Home</u>		ADDRESS 254 Carroll St. N.W. Wash. DC		24a. REC'D BY REGISTRAR DATE, Y 2 1957		24b. REGISTRAR'S SIGNATURE <u>Genevieve Langley</u>	

HOSPITAL OR PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3966

CERTIFICATE OF DEATH

03960

Reg. Dist. No. 94

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Ethel	Middle W.	Last Goodnow	4. DATE OF DEATH 4 6	Month 4	Day 6	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 28 1878		9. AGE (In years lost birthday) 79 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 6	11. BIRTHPLACE (State or foreign country) North East, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. citizen			
13. FATHER'S NAME Robert Ferguson		14. MOTHER'S MAIDEN NAME Hannah Ferguson						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Carcinoma of Esophagus		Carcinoma of Left Lung		INTERVAL BETWEEN ONSET AND DEATH 6 hours		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Chestertown		(County) Cecil Co.
21. I certify that I attended the deceased from <u>Jan 1</u> , 1957, to <u>April 1</u> , 1957, that I last saw the deceased alive on <u>April 16</u> , 1957, and that death occurred at <u>12</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Jan J. Coffey</i> PHYSICIAN'S NAME (Type)						ADDRESS (Street, city or town, state) Chestertown		DATE SIGNED 1957
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 1-19-57		22c. NAME OF CEMETERY OR CREMATORIAL Methodist		22d. LOCATION (City, town, or county) North East, Cecil Co., Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i>		ADDRESS North East, Md.		24a. REC'D BY REGISTRAR DATE April 9-57		24b. REGISTRAR'S SIGNATURE <i>Sarah E. Rothermel</i>		

SUREAU V.

APR 11 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03961

CERTIFICATE OF DEATH

3967

Reg. Dist. No. 91

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Chesapeake City	MARYLAND LENGTH OF STAY (In this place) Life	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chesapeake City	COUNTY Cecil (If rural give location)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS R. F. D.	STREET ADDRESS R. F. D.				
3. NAME OF DECEASED (Type or Print) William Henrey Hinson			4. DATE OF DEATH April 28 1957		
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH July 12 1872	9. AGE last birthday 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Henson			14. MOTHER'S MAIDEN NAME Elizabeth Collins		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO. Unknown	17. INFORMANT & ADDRESS Henrietta Henson Chesapeake M	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) Acute Pneumonalyomatous Nephritis 1 Week					
ANTECEDENT CAUSE(S) DUE TO (B) Virus Grippe 3 Weeks					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) Chronic Pneumonalyomatous Nephritis 4 Years STATING UNDERLYING CAUSE LAST.					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4/15 1957 to 4/28 1957, that I last saw the deceased alive on 4/27 1957, and that death occurred at 8:30 PM, from the causes and on the date stated above. SIGNATURE James L. Johnson DATE SIGNED 4/29/57					
23. BURIAL CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5/4/57	NAME OF CEMETERY OR CREMATORIAL Bethel A.M.E.Cem.	LOCATION (City, town, or county) Bohemia Manor Md.	
24. REC'D BY REGISTRAR DATE 2/3/57		REGISTRAR'S SIGNATURE M. A. Johnson	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edgar Bell 1111 N. E. 6th		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03962

3968

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Harford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon		d. STREET ADDRESS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First ELI	Middle W	Last HOFFMAN	4. DATE OF DEATH	Month April	Day 16, 1957	Year			
5. SEX	6. COLOR OR RACE Male	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> April 21, 1891	9. AGE (In years last birthday) 65	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Minutes 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY/ USA				
13. FATHER'S NAME ELI HOFFMAN		14. MOTHER'S MAIDEN NAME HESTER KERK								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI		17. INFORMANT Unknown Hospital Records, VAH., Perry Point, Md.		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease severe										
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Infarction of myocardium due to arteriosclerotic coronary thrombosis										
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis general severe - unknown										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) VA								
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA		20f. (City or town) Abingdon		(County) Abingdon	(State) Maryland	
21. I certify that I attended the deceased from March 29, 1957 to April 16, 1957 and that death occurred at 11:30 P.M. from the causes and on the date stated above.									ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md.	DATE SIGNED 4-17-57
ACTUAL SIGNATURE <i>W. Oppler</i>		M.D.								
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services								
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-17-57		22c. NAME OF CEMETERY OR CREMATORIAL Cokesbury Cemetery		22d. LOCATION (City, town, or county) Abingdon, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard K. McCormack Jr.</i>		ADDRESS HOWARD K. MCCORMACK & SONS, Abingdon, Md.		24a. REC'D BY REGISTRAR 4-16-57		24b. REGISTRAR'S SIGNATURE <i>James Daugherty Jr.</i>				

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of the Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

10. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03963

Reg. Dist. No. 92

3969

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick		c. LENGTH OF STAY IN lb 20 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Eugene	Middle Hollingworth	Last	4. DATE OF DEATH Month 4 Day 2 Year 1957			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-1890	9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Hand		10b. KIND OF BUSINESS OR INDUSTRY Farm work		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Hollingworth		14. MOTHER'S MAIDEN NAME Semie Larkert					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Bells Funeral Home, Wilmington, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH 420.1 DUE TO Conditions, if any, which goe rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> CAUSE OF DEATH.							
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>R. C. Dodson</i>	DATE SIGNED 4-3-57						
EXAMINER'S NAME (Type) R. C. Dodson	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-7-1957	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Bohemia Manor	22d. LOCATION (City, town, or county) Chesapeake City, Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer Bell</i>	24a. REC'D. BY REGISTRAR DATE 4-4-57	24b. REGISTRAR'S SIGNATURE <i>Mrs. L. Dodson</i>					

Y. V. REAIRE

APR 5 1957

500 V. REAIRE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3950

CERTIFICATE OF DEATH

03964

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Eckton</i>		c. LENGTH OF STAY IN 1b <i>6 weeks</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Eckton RN #3</i>				
d. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Marion C</i>	First	Middle	Last			
4. DATE OF DEATH <i>Howard Jr</i>	Month	Day	Year <i>April 1957</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 19th 1916</i>			
9. AGE (In years last birthday) yrs <i>40</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>			
13. FATHER'S NAME <i>Marion C Howard</i>	14. MOTHER'S MAIDEN NAME <i>Sarah Jane Rinckert</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				
16. SOCIAL SECURITY NO <i>—</i>	17. INFORMANT <i>Marion C Howard</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>057.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. INTERVAL BETWEEN ONSET AND DEATH <i>March 31</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. p. p. m.	Month 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>133 W Main, Elkton</i>	20f. (City or town) <i>Eckton</i>	(County) <i>Caroline</i>	(State) <i>Md</i>
21. I certify that I attended the deceased from <i>April 1, 1957</i> to <i>April 1, 1957</i> that I last saw the deceased alive on <i>April 1, 1957</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Howard Jr</i> PHYSICIAN'S NAME (Type) <i>Dr. Howard Jr</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/2/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Eckton Cemetery</i>	22d. LOCATION (City, town, or county) <i>Eckton</i>	(State) <i>Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Walter Jr. Joseph E. Eckton, Md</i>	ADDRESS <i>2065394 XV5</i>	24a. REC'D BY REGISTRAR DATE <i>4/4/57</i>	24b. REGISTRAR'S SIGNATURE <i>H. J. Frazer</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, removal, and in any event within 72 hours after death.

EURÉAU V. S

APR 5 1964

DEGEIVLE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3970

CERTIFICATE OF DEATH

03965
96

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 16 days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Cecil		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 7 Buckley Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JOSEPH		First	Middle T.	Last JOHNSON	4. DATE OF DEATH April 6, 1898	Month April	Day 25	Year 1957			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1898	9. AGE (In years last birthday) 59 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Swimming Pool		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John M. Johnson		14. MOTHER'S MAIDEN NAME Eva Rambo									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W H I		17. INFORMANT Unknown		Address Hospital Records, VAH, Perry Point, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CARCINOMA OF GALL BLADDER WITH LIVER METASTASIS				INTERVAL BETWEEN ONSET AND DEATH 6 Months					
155 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Arteriosclerosis, generalized						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19 p. m. VA		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from April 9, 1957, to April 25, 1957, and that death occurred at 1:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) W. Oppler, M.D., V.A. Hospital, Perry Point, Md. 4-25-57						DATE SIGNED					
PHYSICIAN'S NAME (Type) W. OPPLER, M.D., Director, Professional Services, VAH., Perry Point, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-57		22c. NAME OF CEMETERY OR CREMATORIAL Brookview		22d. LOCATION (City, town, or county) Rising Sun, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson		ADDRESS J. Earl Tyson, Rising Sun, Maryland		24a. REC'D BY REGISTRAR DATE 4/25/57		24b. REGISTRAR'S SIGNATURE Irene E. Longferry					

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BUREAU V. S.

APR 29 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03966

3971

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 3 mo. 13 days		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION V.A. H.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		f. STREET ADDRESS RFD#1, Box 34A	
3. NAME OF DECEASED (Type or print) WILTON		First A.	Middle 	Last JOHNSON	4. DATE OF DEATH April 12 1957
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6-5-91	9. AGE (in years last birthday) 65 yrs	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Knoxville, Md.	
13. FATHER'S NAME Eugene Johnson		14. MOTHER'S MAIDEN NAME Eliza Johnson		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved INTERVAL BETWEEN ONSET AND DEATH 7-10 days					
151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) Adenocarcinoma stomach with metastasis to liver & DUE TO Lymph nodes UNK.			
		(c) Arteriosclerosis, generalized, moderate UNK.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that attended the deceased from December 29, 1956, to April 12, 1957, and that death occurred at 11:30 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Joseph Grasberger, M.D.		ADDRESS (Street, city or town, state) M.D. V.A. Hospital, Perry Point, Md.		DATE SIGNED	
PHYSICIAN'S NAME (Type) JOSEPH GRASBERGER, M.D.		Acting Dir. of Professional Services.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/19/57		22c. NAME OF CEMETERY OR CREMATORIAL Unknown	
22d. LOCATION (City, town, or county) St. Anne's				(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington, Son, Grace, Md.		ADDRESS		24a. REC'D BY REGISTRAR 1/13/57	
				24b. REGISTRAR'S SIGNATURE Pennington, Son, Grace, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be retained for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

BUREAU V. 2

APR. 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03967

tems 18-21 Film

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

PL

3972

1. PLACE OF DEATH
a. COUNTY

CECIL

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

Port Deposit

c. LENGTH OF STAY IN lb

7 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

236 N. Main St.

3. NAME OF
DECEASED
(Type or print)

First
DAVID
Middle
L

Last
JONES

4. DATE
OF
DEATH

Month
4
Day
21
Year
1957

5. SEX

M

6. COLOR OR RACE

C

7. MARRIED

NEVER MARRIED
 WIDOWED
 DIVORCED

8. DATE OF BIRTH

1-15-1925

9. AGE (in years
less birthday)
32
yrs.

IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days
Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Janitor

10b. KIND OF BUSINESS OR INDUSTRY

U S Navy Exchange. Alabama

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George L. Jones

14. MOTHER'S MAIDEN NAME

Ruby Booth

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
Yes. *6-27-46 to 4-27-1948.*

16. SOCIAL SECURITY NO

16-27-1948

17. INFORMANT

Stella Jones, Port Deposit, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Carbon Monoxide Poisoning

INTERVAL BETWEEN
ONSET AND DEATH

916.0

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

Smothered in conflagration of home.

20c. TIME OF INJURY Month, Day, Year
Hour
4:40 a.m. 4/21/5719

20d. INJURY OCCURRED
While Not while
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)
Home

20f. (City or town)

(County)

(State)

Port Deposit Cecil Md

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and find that
death resulted from: Natural causes Accident Suicide Homicide Undetermined cause

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

PAUL F. GUERIN

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

4-21-57

22a. BURIAL, CREMATION,
BURIER (Specify)

22b. DATE THEREOF
4-30-1957

22c. NAME OF CEMETERY OR CREMATORIUM
Roberts Cemetery, Pratt City, Birmingham, Alabama.

22d. LOCATION (City, town, or county)
(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Lee A. Patterson Son, Perryville, Md.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE 4-27-57 **John E. Daugherty**

BUREAU V. S.

APR 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03968

Reg. Dist. No.

3973

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		c. LENGTH OF STAY IN Tb 15 yrs.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) South Queen		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun				
d. STREET ADDRESS South Queen		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Harry	First Keilholtz	Middle S	Last 4			
4. DATE OF DEATH 27 1957	Month 4	Day 27	Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-7-1875			
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 82 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sexton		10b. KIND OF BUSINESS OR INDUSTRY Cemetery				
11. BIRTHPLACE (State or foreign country) Cecil Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Henry C. Keilholtz		14. MOTHER'S MAIDEN NAME Mary H. Scott				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no. or unknown) no		16. SOCIAL SECURITY NO. none				
17. INFORMANT Alma Keilholtz, Rising Sun, Md.		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 591X DUE TO Chronic Nephritis with dropsy INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)						
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)
						(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>R. C. Dodson</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 4-27-57
EXAMINER'S NAME (Type) R. C. Dodson						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-30-57	22c. NAME OF CEMETERY OR CREMATORIAL Hopewell Gem.	22d. LOCATION (City, town, or county) Port Deposit Cecil Md.			(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph M. Reed Rising Sun Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR APR 30 '57		24b. REGISTRAR'S SIGNATURE <i>W. Deane</i>	

1 **REPUTED MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

U.S. GOVERNMENT

APR 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03969

CERTIFICATE OF DEATH

Reg. Dist. No.

3974

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived b. STATE Maryland)		If institution: Residence before admission b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Rising Sun		c. LENGTH OF STAY IN 1b 38 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Rising Sun		d. STREET ADDRESS 1			
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Charles	Middle Herman	Last Kincaid	4. DATE OF DEATH April	Month - 4 -	Day 1957	Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/19/1877	9. AGE (In years lost birthday) 80 yrs.	10. IF UNDER 1 YEAR; IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY own Farm		11. BIRTHPLACE (State or foreign country) Hartford Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Kincaid		14. MOTHER'S MAIDEN NAME Sarah Knight							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 214-36-9068		17. INFORMANT Mrs. Charles Kincaid Rising Sun, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 2X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				19. INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Rising Sun		(County) Md. (State)	
21. I certify that I attended the deceased from 11-29 , 1956, to 3-31 , 1957, that I last saw the deceased alive on 3-31 , 1957, and that death occurred at Rising Sun, Md. , from the causes and on the date stated above. ADDRESS (Street, City or town, state) Rising Sun, Md. DATE SIGNED RE Dodson, M.D.									
ACTUAL SIGNATURE									
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/7/57		22c. NAME OF CEMETERY OR CREMATORIAL West Nottingham Cem.		22d. LOCATION (City, town, or county) Colona		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James E. McMillan Rising Sun, Md.		ADDRESS 110 Main St. Rising Sun, Md.		24a. REC'D BY REGISTRAR DATE 4-8-57		24b. REGISTRAR'S SIGNATURES West Nottingham			

BUREAU V. S.

APR 6 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3951 CERTIFICATE OF DEATH

05102

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ELKTON</i>		c. LENGTH OF STAY IN 1b <i>40 yrs</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>R.F.D. #1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>JOHN</i>	First <i>K</i>	Middle <i>RE</i>	4. DATE OF DEATH <i>APRIL 21 1957</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>FEB 15 1889</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CABINET MAKER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>CARPENTER</i>	11. BIRTHPLACE (State or foreign country) <i>Austria - Czech</i>			
13. FATHER'S NAME <i>JOHN KREJCI</i>		14. MOTHER'S MAIDEN NAME <i>MATILDA FROL</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. <i>218-28-6349-A</i>	17. INFORMANT <i>MARTHA KREJCI RFD #1 Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>15X</i>		DUE TO <i>Carcinoma of Stomach</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1952</i>				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Hour a. p. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from _____, 1952, to April 21, 1957, that I last saw the deceased alive on April 19, 1957, and that death occurred at <i>10 SP</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>ADDRESS</i> DATE SIGNED <i>April 22, 1957</i>						
ACTUAL SIGNATURE <i>Dr. Edward H. Spangler, M.D.</i>						
PHYSICIAN'S NAME (Type) <i>MILFORD H. SPANGLER, M.D.</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>4/24/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>GILPIN MANOR MEMPK</i>	22d. LOCATION (City, town, or county) <i>NR. ELKTON</i>	(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Henry Dugay</i>		ADDRESS <i>ELKTON, MD.</i>	24a. REC'D BY REGISTRAR DATE <i>4/25/57</i>	24b. REGISTRAR'S SIGNATURE <i>21/7 Fugue</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03971

3952 CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Baltimore		c. LENGTH OF STAY IN 1b 13 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Charles	Middle E	Last Lort	4. DATE OF DEATH 10 11 16	Month Day Year 1957		
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1900	9. AGE (in years lost birthday) 67 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Telegrapher		10b. KIND OF BUSINESS OR INDUSTRY Penns R.R.		11. BIRTHPLACE (State or foreign country) Leisville Penna		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Dr. Joseph Lort		14. MOTHER'S MAIDEN NAME Martha A. McCleary					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 717-07-5746		17. INFORMANT Mrs Charles B. Lort		Address North East, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Nephritis				INTERVAL BETWEEN ONSET AND DEATH 7 days	
44d0.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Nephrosclerosis + Coronary atherosclerosis Generalized Arteriosclerosis				2 months 8 yrs.	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 March, 1957, to 16 April, 1957, that I last saw the deceased alive on 15 April, 1957, and that death occurred at 2:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		Klaus H. Huebner M.D.		ADDRESS (Street, city or town, state) North East, Md.		DATE SIGNED 16 April 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) 1-1-1957		22b. DATE THEREOF 1-1-1957		22c. NAME OF CEMETERY OR CREMATORIAL Method		22d. LOCATION (City, town, or county) North East, Cecil Co., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Grant		ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE 4/19/57		24b. REGISTRAR'S SIGNATURE John J. League	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3975

CERTIFICATE OF DEATH

Reg. Dist. No.

03972

91

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN 1b 3 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Morgan Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
3. NAME OF DECEASED (Type or print) Bessie		d. STREET ADDRESS Singerly Road	
4. DATE OF DEATH April 19 1957		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Smith		14. MOTHER'S MAIDEN NAME Susan Lemon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Curtis E. Moore		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Cordic dilatation	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 12 mos 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Diabetes	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1950, to Apr 19, 1957, that I last saw the deceased alive on 4/18, 1957, and that death occurred at 7 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE J. HERBERT BATES PHYSICIAN'S NAME (Type) J. HERBERT BATES			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/1957	
22c. NAME OF CEMETERY OR CREMATORIAL SHARPS Cemetery		22d. LOCATION (City, town, or county) (State) Cecil county, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. E. HICKS		24a. RECEIVED BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE J. HERBERT BATES			

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 1044 1045 1046 1047 1048 1049 1050 1051 1052 1053 1054 1055 1056 1057 1058 1059 1060 1061 1062 1063 1064 1065 1066 1067 1068 1069 1070 1071

BUREAU

- 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03973

3953

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 5 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		d. STREET ADDRESS 117 Bridge Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MAE B. ORENDRF		First	Middle	Last	4. DATE OF DEATH 4	Month	Day	Year 16 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept 28, 1900	9. AGE (In years last birthday) 56 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing		10b. KIND OF BUSINESS OR INDUSTRY Judy Lynn Frocks Inc. - Elkton		11. BIRTHPLACE (State or foreign country) Dover, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME William H. Baker		14. MOTHER'S MAIDEN NAME Laura Brenman						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 212-26-1530		17. INFORMANT Charles W. Orendorf, Elkton, Maryland		Address 117 Bridge Street, Elkton, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest						INTERVAL BETWEEN ONSET AND DEATH 1 hr.		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma, right lung						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Elkton	(County)	(State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ PM, from the causes and on the date stated above. ACTUAL SIGNATURE John A. Fischer						ADDRESS (Street, city or town, state) 138 W. MAIN ST, Elkton, Md DATE SIGNED 4/16/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 20, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Gilpin Manor Mem. Park		22d. LOCATION (City, town, or county) Cecil County, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		ADDRESS 103 Stockton Street Elkton, Maryland		24a. REC'D BY REGISTRAR DATE 4/17/57		24b. REGISTRAR'S SIGNATURE John Fischer		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03974
92

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 9 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
3. NAME OF DECEASED (Type or print) Margaret		First Margaret	Middle Parrish
4. DATE OF DEATH 4 15 1957		Month 4	Day 15
5. SEX Female		6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH July 18, 1901		9. AGE (In years last birthday) 55	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Richmond, Va.
13. FATHER'S NAME Benjamin Russ		14. MOTHER'S MAIDEN NAME Sarah Mayo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Doris Tinsley-142 E. High St., Elkton
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Liver cirrhosis		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Cholelithiasis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Ascites, General weakness		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour p. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-15 , 1957, to 4-15 , 1957, that I last saw the deceased alive on 4-15 , 1957, and that death occurred at 10 p.m. from the causes and on the date stated above. ACTUAL SIGNATURE Edgar Bell PHYSICIAN'S NAME (Type) OTTO VOGEL MD		ADDRESS (Street, city or town, state) 4027th EAST 4-16-57 DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/20/57	22c. NAME OF CEMETERY OR CREMATORIAL Providence Cem.
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Bell		ADDRESS Wells, Dela	24a. REC'D BY REGISTRAR DATE 4/20/57
			24b. REGISTRAR'S SIGNATURE HR Frazer

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OR 23 1957

DECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3955

Reg. Dist. No.

03975

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		b. COUNTY	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS 1606 N. Caroline	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Marian	Middle Amy	Last Schenck
4. DATE OF DEATH	Month 4	Day 24	Year 1957
5. SEX	6. COLOR OR RACE F.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-6-1909
9. AGE (In years last birthday) 47 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Amy		14. MOTHER'S MAIDEN NAME Melvina Moody	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple pulmonary emboli from thrombophlebitis</u> 816X 30078 <u>right leg due to fracture of right leg</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Hit another car and a light pole	
20c. TIME OF INJURY Month, Day, Year Hour 6:27 4-7-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40 20f. (City or town) Northeast Cecil Md. (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>R.S. Fisher</i>		DATE SIGNED 4/25/57	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-29-57	
22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		ADDRESS 802 Madison Avenue	
24a. REG'D BY REGISTRAR APR 25 1955		24b. REGISTRAR'S SIGNATURE <i>Rodney Dryers</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

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1357

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03976

CERTIFICATE OF DEATH

Reg. Dist. No. 24

3955

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X-1 North East MD 1					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Simmer		First John	Middle Simmer	Last John	4. DATE OF DEATH April 5 1951	Month April	Day 5	Year 1951	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH M; 10, 1891	9. AGE (In years last birthday) 65 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard Ret		10b. KIND OF BUSINESS OR INDUSTRY Aerial Products		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William J. Simmers		14. MOTHER'S MAIDEN NAME Sarah Kisiner							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Brown Simmers		Address North East Rd 1, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1998 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c)		Carcinoma of the lungs stomach and upper maxillary		INTERVAL BETWEEN ONSET AND DEATH Since 1-1-51					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) North East		(County) Cecil	(State) MD
21. I certify that I attended the deceased from April 15, 1951, to April 1, 1951, that I last saw the deceased alive on April 4, 1951, and that death occurred at 9 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Reed Dawson</i> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <i>R. E. Dawson</i> DATE SIGNED 4-15-51 <i>Reed Dawson MD 4-65</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Friends		22b. DATE THEREOF 4-0-1-57		22c. NAME OF CEMETERY OR CREMATORIAL Friends		22d. LOCATION (City, town, or county) North East, MD		(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Shantz</i>		ADDRESS North East, MD		24a. REC'D BY REGISTRAR DATE 4/8/57		24b. REGISTRAR'S SIGNATURE <i>H. J. Springer</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PURÉAU Y.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3976

CERTIFICATE OF DEATH

03977
Reg. Dist. No. 96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician, it may be retained by the hospital or attending physician. If institution: Residence before admission

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be retained by the funeral director. If institution: Residence before admission

page 3 should be retained for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware		b. COUNTY New Castle		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 27 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington		d. STREET ADDRESS 1502 Faulkland Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) HUBERT		First J.	Middle THUET	Last	4. DATE OF DEATH April	Month 21	Day 1957	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 14, 1890		9. AGE (In years lost birthday) 66 yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drill Press Operator		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Wilmington, Delaware		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Hubert Thuet		14. MOTHER'S MAIDEN NAME Catherine Muller						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Adeno carcinoma of the colon (sigmoid) with wide spread metastasis to the abdominal organs and to the brain				INTERVAL BETWEEN ONSET AND DEATH Unknown		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Wilmington		(County)		(State)
21. I certify that <u>VA</u> offended the deceased from <u>March 25</u> , 1957, to <u>April 21</u> , 1957, <u>XXXXXX</u> and that death occurred at <u>5:22 P.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 4-22-57		
ACTUAL SIGNATURE <u>W. Oppeler</u>				M.D. Perry Point, Maryland				
PHYSICIAN'S NAME (Type) W. OPPLER, M. D., Director, Professional Services, VAH, Perry Point, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-22-57		22c. NAME OF CEMETERY OR CREMATORIAL CATHEDRAL CEM.		22d. LOCATION (City, town, or county) Wilmington		(State) Del.
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin Ror</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE 4-22-57		24b. REGISTRAR'S SIGNATURE Jesse E. Dougherty		

BUREAU V.

APR 24 1957

REGELIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3977 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03978

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton RD 3		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Elkton RD 3		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First John	Middle W.	Last Wicks	4. DATE OF DEATH April 6 1957	Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Oct 16, 1877	
9. AGE (In years last birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. KIND OF BUSINESS OR INDUSTRY Farm Owner		12. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Samuel Wicks		14. MOTHER'S MAIDEN NAME Frances Johnson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. none		17. INFORMANT Elsie Barnett		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 4201 Coronary Occlusion		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-10-1957		22c. NAME OF CEMETERY OR CREMATORIAL Leeds Methodist		22d. LOCATION (City, town, or county) Elkton R.D. 2 Cecil Co.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Brown				24a. REC'D BY REGISTRAR DATE 4/8/57			
VS. ATMS(E5) SM 9/55				24b. REGISTRAR'S SIGNATURE J. R. Frazer			

BUREAU V. S

APR 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03979

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hosp.		e. STREET ADDRESS R. F. D. #2	
65 3. NAME OF DECEASED (Type or print) WALTER		4. DATE OF DEATH April 3 Month Day Year 1957	
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Retired		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Samuel Wood		14. MOTHER'S MAIDEN NAME Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. If yes, give war or dates of service)	17. INFORMANT Mrs. Annie Wood R. D. #2 Elkton, Md. Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days. 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gastroenteritis, and urinary retention		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 25, 1957</u> to <u>April 3, 1957</u> that I last saw the deceased alive on <u>April 2, 1957</u> , and that death occurred at <u>7:05 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Henry J. Davis</u> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type)		DATE SIGNED <u>Chesapeake City, Md</u> <u>4/3/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-6-1957	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Cherry Hill, Cemet. <u>2579 Elmwood St.</u> Elkton Md.
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Lippin</u>		24a. REC'D BY REGISTRAR DATE <u>4/5/57</u>	24b. REGISTRAR'S SIGNATURE <u>J. R. Frazer</u>

WISCONSIN STATE DEPT. OF EDUCA-
TION - BUREAU OF

CERTIFICATES OF DEATH

REGISTRATION

BUREAU V.

APR 9 1957

RECEIVED